MEMORANDUM

DEPARTMENT OF COMMUNITY HEALTH

LANSING, MICHIGAN 48913

May 23, 2005

TO: Prepaid Inpatient Health Plan (PIHP) Executive Directors

FROM: Irene Kazieczko, Director
Bureau of Community Mental Health Services
Mental Health and Substance Abuse Administration

SUBJECT: Mental Health System Transformation Practice Improvement Infrastructure Development Fiscal Year (FY) 2006/2007 and FY 2007/2008 Community Mental Health Block Grant Request for Applications
Submission Deadline: July 27, 2005

In August 2004, MDCH convened the Evidence-Based Practice Steering Committee made up of representatives of PIHPs and their affiliate members, consumers, advocates, educators, and MDCH staff. The committee examined and shared information about mental health evidence-based practices and has recommended practices and strategies to support the implementation of evidence-based practices in Michigan. The Steering Committee's vision is that all consumers within the Community Mental Health System in Michigan will have access to services that are of high quality, culturally relevant, and evidence-based. The Michigan Department of Community Health (MDCH) is committed to these principles and we invite you to demonstrate your support and participation by responding to this notification.

By issuing this Request for Proposals (RFP), MDCH is continuing certain system transformation efforts, as specified in the MDCH plan for implementing recommendations of the Michigan Mental Health Commission, "Transforming Mental Health Care in Michigan," published in April 2005. This RFP is designed to (1) create the leadership infrastructure necessary to support and guide system transformation efforts; and (2) promote the diffusion of evidence-based practices such as Family Psychoeducation, Integrated Treatment for Co-occurring Disorders, and Parent Management Training Oregon Model (PMTO) throughout our public mental health system.

The adoption of evidence-based practices should be understood as part of each PIHP's responsibility to offer program choices that are likely to result in outcomes that are highly valued by consumers and their families. Expanding the service array to include such practices is fully consistent with the principles of person-centered planning and family-centered practice for children. People may choose to use or not use these services after they have received sufficient information to form their choice.

Prior to completing this application, PIHPs and affiliate members should examine the SAMHSA CMHS website regarding evidence-based practices at:

http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp

Any PIHP that receives block grant funding for a practice will be required to have a representative serve on the Evidence-Based Practice Steering Committee's Subcommittee for that practice. Information about these upcoming meetings will be sent to you under separate cover.

We look forward to receiving your response.

Enclosure

cc: PIHP Affiliate Members
SA CA Executive Directors
EBP Steering Committee Members
MHSA Management Team

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF COMMUNITY MENTAL HEALTH SERVICES

Mental Health System Transformation
Practice Improvement Infrastructure Development

BLOCK GRANTS
REQUEST FOR PROPOSALS

FY 2005/2006 and FY 2006/2007
ONE-TIME ONLY FUNDING
SUBMISSION DUE DATE: JULY 27, 2005

Attachments

A) Face Sheet
B) Application Budget Forms
C) Co-Occurring Disorders: Integrated Dual Disorder Treatment Template for PIHP Planning and Implementation
D) Family Psychoeducation Template for PIHP Planning & FPE Checklist
E) Parent Management Training Oregon Model Application, Project Work Plan, Readiness Checklist
F) Definitions
G) Resources
H) Submission Checklist

Purpose

MDCH is engaged, with its stakeholders, in a systems transformation process. In February 2005, MDCH issued a Request for Proposal (RFP) that set forth its vision for a transformed public mental health system:

Michigan's children, families, and adults will have access to a public mental health and substance abuse service system that supports individuals with mental illness, emotional disturbance, developmental disabilities and substance use disorders by promoting good mental health, resiliency, recovery, and the right to control one's life within the context of the benefits and responsibilities of community membership.

CMHSPs were encouraged to submit proposals to obtain federal mental health block grant funds for the development and implementation of new adult services initiatives consistent with this vision.

In issuing this second RFP, MDCH continues certain system transformation efforts as specified in the MDCH plan for implementing recommendations of the Michigan Mental Health Commission, "Transforming Mental Health Care in Michigan," published in April 2005. This Request for Proposals is designed to (1) create the leadership infrastructure necessary to support and guide system transformation efforts; and (2) promote the diffusion of evidence-based practices, e.g., Family Psychoeducation, Integrated Treatment for Co-occurring Disorders, and Parent Management Training (PMTO) throughout our public mental health system. A maximum amount of $140,000 over two years, is available to those applicants who can demonstrate the leadership and organizational capacity to successfully implement one or more of the adult practices during the two next fiscal years. Specific funding for the PMTO children's practice is based on a competitive process and will fund training of up to two staff within 9 PIHPs.

Each PIHP must understand the importance of adopting evidence-based practices. It is the PIHP's and their affiliate members' responsibility to offer program choices that are likely to result in outcomes that are highly valued by consumers and their families. Expansion of the service array to include such practices is consistent with the principles of person-centered planning and family centered practice for children. People may choose to use or not use these services after they have received sufficient information to inform their choice.

Background

National and state commissions have identified opportunities for improving public mental health systems. In 1999 the Surgeon General issued the landmark surgeon general report on mental health, noting the importance of overall health and well-being to the strength of a Nation and its people. In 2003 the President's New Freedom Commission for Mental Health called for a fundamental transformation of the behavioral health system. This recommendation rested on two basic principles - that care is consumer and family centered and that it facilitates recovery and builds resilience. Issued in October 2004, the Michigan Mental Health Commission's report included seven goals for system transformation, including a recommendation to continue to use

state resources to support best practice. In April 2005 the MDCH issued its plan for implementing recommendations of the Mental Health Commission.

As part of several activities in systems transformation, MDCH convened theEvidence-Based Practice Steering Committee, which is examining mental health practices that are evidence based, promising practices, and emerging practices. It has selected three evidence-based practices for focused implementation over the next two to three years: Co-Occurring Disorders: Integrated Dual Disorder Treatment; Family Psychoeducation; and Parent Management Training. MDCH has also committed to work on improving model fidelity with the state's existing Assertive Community Treatment services and Supported Employment services.

The remainder of this document is devoted to explaining the application process and the information that must be provided to MDCH to warrant financial support.

Steps for the Application Process

Required:

First, each PIHP must identify an Improving Practices Leader and form an Improving Practices Leadership Team for Systems Transformation for both adults and children. This is addressed in Part I.

Second, each PIHP must implement one of the two adult evidence-based practices selected. Limited Community Mental Health Services Block Grant funds are available to assist PIHPs in the implementation process.

Optional:

It is expected, but not mandatory, that each PIHP will use the available block grant funding to assist in development and implementation of one of the adult practices. This funding will be available to each PIHP that submits a completed application for either Co-Occurring Disorders: Integrated Dual Disorder Treatment **or** Family Psychoeducation. This is addressed in detail of Part II of this document. PIHPs that are requesting block grant funds for one of these two practices must complete Part II. Part II.A covers Co-Occurring Disorders: Integrated Dual Disorder Treatment and Part II.B covers Family Psychoeducation.

Third, for children's services, limited Community Mental Health Block Grant funding is available on a competitive basis to PIHPs for implementation of Parent Management Training Oregon Model. Details on this are included in Part III of this document. PIHPs that are applying for Parent Management Training Oregon Model must complete Part III.

PART I – Improving Practices

Funding available through this second RFP is aimed at fueling system transformation by building capacities of community mental health organizations to:

- Adopt a vision for a transformed system of care for adults and children;
- Establish leadership capabilities and organizational capacity to communicate the vision and lead the transformation;
- Create an environment or climate of working that is receptive and amenable to the transformation;
- Develop and communicate a strategy that is tailored to the context and the roles, capabilities, and interests of the stakeholder groups involved in the public mental health system;
- Identify and mobilize program leaders or change agents within the organization to implement the activities required to achieve the desired outcomes;
- Develop an ongoing process to maximize opportunities and overcome obstacles; and
- Monitor outcomes and adjust processes based on learning from experience.

PIHPs and their affiliate members are invited to partner with MDCH transformation efforts by submitting applications that describe how they will

- Align relevant persons, organizations, and systems to participate in a transformation process;
- Assess parties' experience with change;
- Establish effective communications/messages and communication systems;
- Ensure effective leadership capabilities;
- Clarify roles;
- Ensure that stakeholders understand the transformation process and requirements;
- Enable structures and process capabilities;
- Improve cultural capacity; and
- Demonstrate their progress in system transformation by implementing at least one of the two evidence-based programs described in this RFP.

As part of the systems change process, each PIHP will identify one person employed by the PIHP who is providing the leadership related to Improving Practices. This person will have overall responsibility for the PIHP's study and implementation of Evidence-Based Practices, Promising Practices, and Emerging Practices (see Definitions, Attachment F).

This Improving Practice Leader will form a PIHP "Improving Practices" Leadership Team. It will oversee implementation of Evidence-Based Practices, Promising Practices, and Emerging Practices by the PIHP. The goal will be to offer an improved array of services to adults, and to children and their families, from which they may choose. The Improving Practices Leadership Team from each PIHP will link with the state Evidence-Based Practice/Improving Practices initiative.

The Improving Practices Leadership Team will develop work plans, coordinate the regional training and technical assistance plan, work to integrate data collection, develop financing strategies and mechanisms, assure fidelity, evaluate the impact of the practices, and monitor clinical outcomes. It is expected that most of the team members will be experienced in person-centered planning and in family-centered practice for children, and that at least one member be knowledgeable about self-determination.

The team must include at least one member in the following capacities:

- Improving Practice Leader
- Specialists in each of these areas: Services for Individuals with Serious Mental Illness (SMI), Services for Children with Serious Emotional Disturbance (SED), Services for Individuals (adults and children) with Developmental Disabilities (DD) and Services for Individuals with Substance Disorders (SA).
- Finance
- Data
- Evaluation
- Consumer – employed by the PIHP or subcontract agency
- Family member of a child receiving PIHP services
- An identified program leader for each practice being implemented by the PIHP
- An identified program leader for peer-directed or peer-operated services
- A peer support specialist

The PIHP may include other members of its choosing to meet its needs.

Part I Submission Requirements:

PIHP Leadership
Please indicate the name and a brief description of the qualifications/experience of each of the following for the Improving Practices Leadership Team (use as many pages as necessary):

	Name	Qualifications/Experience
Improving Practices Leader		
Specialist in MI Services		
Specialist in SED Services		
Specialist in DD Services		
Specialist in SA Services		
Finance		

Data		
Evaluation		
Consumer – Employed the PIHP or Subcontract Agency		
Family Member of a Child		
Program leader for each practice being implemented		
Program leader for peer-directed or peer-operated services		
Peer Support Specialist		
Other member(s) (please specify for each)		

The PIHP must also submit a one-page summary of how the Improving Practices Leadership Team will be operationalized. It is expected that some members of this team will be members of subcommittees or work groups dealing with the implementation of the practice, or practices, selected by the PIHP for implementation.

PART II – Adult Practices

PIHPs must select one of the two identified adult practices for implementation in FY 05/06. Implementation must be based on the SAMSHA Resource Kit for the practice. PIHPs are encouraged to plan for and implement multiple evidence-based practices if possible. Community Mental Health Block Grant funds are being made available to assist each PIHP with Co-Occurring Disorders: Integrated Dual Disorder Treatment **or** Family Psychoeducation. One-time funding will be available for FY 05/06 and for FY 06/07. The total amount of funding available to each PIHP for its selected practice over the two-year period is $140,000. The PIHP may divide the amount between the two years, with the stipulation that no more than $100,000 may be used during each of the two fiscal years. These funds are not being awarded on a competitive basis. Funding for one of the two practices is available to every PIHP that completes submission requirements contained in this document. The budgets may include PIHP infrastructure activities that are directly related to building capacity for improving practices for adults and children. The PIHP must commit to sustaining the system capacity for improving practices and to sustaining its implementation of the selected evidence-based practice.

A. Co-Occurring Disorders: Integrated Dual Disorder Treatment

BACKGROUND

One of the Evidence-Based Practices selected for implementation by the Evidence-Based Practice Steering Committee is Co-Occurring Disorders: Integrated Dual Disorders Treatment. PIHP representatives, Substance Abuse Coordinating Agency representatives, DCH staff, consumers, advocates, and educators have come together in a subcommittee to work toward the implementation of this Evidence-Based Practice in the State of Michigan. This information on the work of the subcommittee may be helpful as PIHPs consider the identification and implementation of Evidence-Based Practices.

The draft mission statement of the Co-Occurring Disorders: Integrated Dual Disorder Treatment Subcommittee follows:

Individuals with Co-Occurring serious mental illness and substance disorder will receive services that support their recovery. This will be promoted by the Co-Occurring Disorders: Integrated Dual Disorder Treatment subcommittees through:

a. Support of system level changes that promote the provision of integrated services, with acknowledgement of differing phases of system change, and provision of the opportunity for involvement and access to resources matched to that phase.

b. Support of the implementation of the SAMHSA Co-Occurring Disorders: Integrated Dual Disorder Treatment enhanced services model for individuals with co-occurring serious mental illness and substance disorder in communities at a phase of change that can support this enhanced service model.

Three subcommittee work groups have been meeting and developing action plans related to this mission. The Administration, Legal and Policy Workgroup is focusing on issues related to system and program infrastructure. The Training and Program Development Work Group is addressing technical assistance and training needs for program development and staff development. The Measurement Work Group has recently expanded to include representatives from the Family Psychoeducation and Parent Management Training subcommittees to assure that the measurement and evaluation of Evidence-Based Practices is coordinated across practices. Members from each of the work groups also participate in the Co-Occurring Policy Academy, and are addressing the coordination of the work of these two groups. The COD Subcommittee is focusing on piloting Co-Occurring Disorders: Integrated Dual Disorders Treatment for adults with serious mental illness and co-occurring substance disorder, whereas the Co-Occurring Policy Academy is focusing on policy issues related to Integrated Treatment for all populations with co-occurring mental illness and substance disorder.

The action plans developed by the subcommittee work groups are aimed at supporting communities in implementing Integrated Treatment through a quality improvement focus, rather than a compliance focus. Tools for navigating the complexities of our systems are provided so that implementation of this practice will not be avoided or delayed because of those complexities. Based on this focus, the action plans include some of the following elements:

- Resources and technical assistance will be available to PIHPs to promote system change that supports Integrated Treatment. PIHPs can identify this Evidence-Based Practice as a project in the next year regardless of their stage of system change.
- Resources and technical assistance will also be available for those PIHPs who are ready to implement the SAMHSA Toolkit for Integrated Dual Disorders Treatment for adults with a serious mental illness.
- PIHPs that identify this Evidence-Based Practice as a project will be asked to complete a self- assessment using the CO-FIT for their system, and develop action plans based on this self-assessment.
- DCH monitoring of the PIHP's progress related to this Evidence-Based Practice will be based on each PIHP's progress on their action plans. State monitoring will not be based on compliance with Evidence-Based Practice Toolkit standards.
- The Measurement Work Group will be identifying indicators and tools for evaluation and measurement related to this EBP. The information from this data will be used for local and state quality improvement efforts, not contract compliance purposes.
- Stakeholder participation in this effort is important. We will continue to encourage consumer participation and substance abuse and mental health system participation throughout the course of the project.
- Participation from PIHP project sites is important in implementing and promoting this Evidence-Based Practice in the State of Michigan. PIHPs will be asked to assist in identifying and addressing implementation issues by participating in work groups and technical assistance opportunities throughout the course of the project.

There are a number of opportunities to participate or learn more about this project at this time, including the following:

- Many PIHPs have staff participating in the subcommittee. We encourage all PIHPs to support their representatives participating in the subcommittee. PIHPs that choose to implement this practice will be required to have a representative on the subcommittee. Sharing of experiences by participants allows individual PIHPs and affiliates, as well as the entire state system, to move forward more smoothly and with more consistency.

- Each subcommittee work group is chaired by two individuals. We encourage PIHPs to contact the co-chairs with any questions or input regarding the implementation of this Evidence-Based Practice (see reference list for contact information).

- The May Board Association conference will include more information on the implementation of Evidence Based Practices in the Michigan, and specific information on Integrated Dual Disorders Treatment.

Requirements for Applications for Funding for Co-Occurring Disorders: Integrated Dual Disorder Treatment:

The following steps are based on the work plan developed by the Co-Occurring Disorders: Integrated Dual Disorder Treatment Subcommittee. These are considered essential elements, and a logical progression, in developing, first the system capacity, and then the evidence-based practice itself. These steps are included in Attachment C, COD:IDDT Template for PIHP Planning and Implementation. PIHPs applying for funding for this practice must complete Attachment C, indicating which activities are accomplished, in the planning process, or not yet begun. Please note that many activities that are "accomplished" are ongoing activities needed to sustain the practice.

A PIHP is eligible for funding for this practice regardless of where it is in the planning process. It may be at the beginning, somewhere in the middle, or nearer to complete implementation. The work plans must address how the PIHP will use block grant funds to accomplish the next steps in the process. For this practice, complete implementation is not expected in the first year, or even the second year, if the PIHP is at the beginning stages of planning.

The Planning and Implementation Steps are:

1. PIHP convenes meetings with other stakeholders including Substance Abuse Coordinating Agencies to address co-occurring disorders.
2. PIHP identifies a program leader for Co-Occurring Disorders: Integrated Dual Disorder Treatment.
3. PIHP access centers have profession staff who are trained to screen for both mental illness and substance disorders.
4. Individuals entering the mental health system, or receiving ongoing services, are routinely screened for co-occurring substance disorders.
5. PIHP forms an ongoing work group of administrators to address Co-Occurring Disorders: Integrated Dual Disorder Treatment.
6. PIHP forms an ongoing work group of clinicians to address Co-Occurring Disorders: Integrated Dual Disorder Treatment.
7. PIHP uses the COFIT to assess where the system is with respect to its ability to serve people with co-occurring disorders.
8. PIHP develops an Action Plan that addresses co-occurring capability for the system as a context for the implementation of the COD:IDDT Resource Kit and includes identified training and technical assistance needs.
9. Providers use the COMPASS to assess themselves.
10. PIHP builds ongoing training and teamwork into its system.
11. PIHP assesses the system at regular intervals using the CoFIT-100.
12. Providers assess themselves at regular intervals using the COMPASS.
13. The General Organizational Index (GOI) and the IDDT Fidelity Tool are administered to determine the degree of implementation.
14. PIHP Action Plan includes steps to reach full implementation to meet fidelity of the Co-Occurring Disorders: Integrated Dual Disorder Treatment Evidence-Based Practice.
15. PIHP maintains involvement with all relevant regional systems and stakeholder.

16. PIHP provides or arranges for ongoing technical assistance and training needs for PIHP and provider staff.
17. PIHP identifies areas of needed clinical improvement and works with work groups to address needs.
18. PIHP shares successes and barriers in Co-Occurring Disorders: Integrated Dual Disorder Treatment implementation with other regions.
19. PIHP fully implements the Co-Occurring Disorders: Integrated Dual Disorder Treatment Evidence-Based Practice.
20. Ongoing support for, and measurement of, the model is maintained.

B. Family Psychoeducation

Family Psychoeducation is a specific method of working in partnership with consumers and families in a long-term treatment model to help them develop increasingly sophisticated coping skills for handling problems posed by mental illness. The goal is that practitioner, consumer, and family work together to support recovery. Common issues include participation in outpatient programs, understanding prescribed medication, alcohol or other drug abuse, and symptoms that affect the consumer. Family Psychoeducation respects and incorporates individual, family, and cultural perspectives. It engenders hope in place of desperation and demoralization.

The Evidence-Based Practice Steering Committee has a Family Psychoeducation Subcommittee that has been working since September to develop a strategy for assisting PIHPs who choose to implement Family Psychoeducation. Participants on the subcommittee include consumers, and representatives from a PIHP that is currently implementing Family Psychoeducation (Washtenaw Community Health Organization), PIHPs that are beginning implementation (Northcare and Oakland), and PIHPs that are interested in implementing this EBP. The subcommittee also includes representatives from the University of Michigan who are assisting with the current implementation, and are interested in assisting PIHPs that will select Family Psychoeducation. The University's key role is to help with fidelity monitoring and development of an outcomes evaluation strategy.

The PIHP should be knowledgeable about the Family Psychoeducation model developed by the National Evidence Based Practices Project. The PIHP will utilize the fidelity scale contained in the toolkit as part of its quality improvement program. As with other EBPs there are the expectations that:

- DCH monitoring of the PIHPs progress related to this EBP will be based on each PIHPs progress on their work plans. State monitoring will not be based on compliance with EBP Toolkit standards.
- The Measurement Work Group will be identifying indicators and tools for evaluation and measurement related to this EBP. However, the information from this data will be used for local and state quality improvement efforts, not contract compliance purposes.
- Stakeholder participation in this effort is important. We will continue to encourage consumer participation and PIHP participation throughout the course of the project.

- Participation from PIHP project sites is important in implementing and promoting this EBP in the State of Michigan. PIHPs will be asked to assist in identifying and addressing implementation issues by participating in work groups and technical assistance opportunities throughout the course of the project.

Requirements for Applications for Funding for Family Psychoeducation:

1. PIHP convenes meetings with stakeholders, including advocacy and consumer groups.
2. PIHP identifies a program leader for Family Psychoeducation.
3. PIHP forms an ongoing work group of clinicians, consumers and administrators to address the implementation and obtaining continuous feedback.
4. PIHP develops a consensus building process around the SAMHSA Resource Kit. This includes model fidelity and implementation strategies, disseminating program documents, develop training plan for the staff.
5. PIHP develop, revise and implement workflow and other administrative process including information system requirements.
6. PIHP provides or arranges for ongoing technical assistance and training needs for the staff and/or providers.
7. PIHP develop defined competencies for clinical staff.
8. PIHP uses General Organizational Index and fidelity scales at regular intervals to evaluate the model fidelity of the program.
9. PIHP identifies areas of needed clinical improvement and works with work groups to address needs.
10. PIHP shares successes and barriers in implementing FPE with State EBP Steering committee and other regions.

PIHPs that are submitting proposals for assistance with implementation of Family Psychoeducation must submit a work plan that addresses the activities, milestones, dates, persons responsible and outcomes. In addition, PIHPs must complete the items on the checklist included, and include the checklist with the application. The template and checklist are included in Attachment D.

PART III – Children's Practice

Parent Management Training Oregon Model

Background

The evidence-based practice identified for children by the Evidence-Based Practice steering committee was Parent Management Training-Oregon Model (PMTO). PIHP/CMHSP representatives, MDCH staff, parent representatives, and universities came together in the PMTO subcommittee work to develop a work plan for implementation of PMTO across the state of Michigan. The work plan from this subcommittee is available as part of Attachment E.

The overall goal for the PMTO Subcommittee was to improve child and family well-being by increased use of evidence based practices and outcome management. Outcomes identified by the subcommittee include: 1) PMTO will be implemented statewide with model fidelity; 2) Improved child and family functioning; 3) Improved family satisfaction with services; 4) Improved parenting skills 5) Improved staff skills/competency in PMTO. Measures include monitoring model fidelity by videotaping therapy sessions, the use of the CAFAS to measure client outcomes, the use of family satisfaction questionnaire has been developed to be used after each session with the families, and a scale entitled Caregiver Wish List has been developed to use with families to help engage then in a discussion about their parenting practices and help the therapist assess families parenting skills in a way that will engage families. We will train staff and work with them to monitor fidelity and their skills in using PMTO.

Staff from MDCH will partner with PIHPs, Eastern Michigan University and the Oregon Social Learning Center to coordinate the training to be provided. Resources will be available from the partnership of MDCH, EMU, and OSLC staff throughout the training, implementation and evaluation of PMTO in Michigan. We will work with each PIHP that is selected to ensure success of this project. We will work to solve problems as they arise and to seek solutions to those problems together. Participation from PIHPs and consumers in implementing this evidence-based practice is critical. We will continue to seek input throughout implementation of this exciting new evidence based practice.

There are a number of opportunities to participate or learn more about this project. They include the following:

- Many PIHPs have staff currently participating on the PMTO Subcommittee. We encourage PIHPs to support their representatives on the subcommittee. PIHPs that are selected to participate will be required to have a representative on the PMTO subcommittee.

- The May Michigan Association of Community Mental Health Boards (MACMHB) conference will include a great deal of information about PMTO.

- PIHPs desiring more information about PMTO can attend, in person or by phone, the next PMTO Subcommittee meeting to be scheduled in June.

PMTO Model Summary

The Parent Management Training – Oregon Model was originally developed by Patterson and colleagues at the Oregon Social Learning Center. PMTO is a manualized, evidence-based practice based on social interaction learning theory. PMTO is tailored for youth from preschool to adolescence with serious behavior problems, including antisocial behavior, internalizing problems, delinquency, substance abuse, and school failure. PMTO is a family intervention designed to empower parents and build on family strengths. PMTO training consists of:

1) Skill Encouragement: Teaching new behavior through positive contingencies,
2) Limit Setting: Discouraging problematic behavior through negative noncorporal sanctions,

3) Monitoring/Supervision: Attending to children's behavior at home and away from home,
4) Family Problem Solving: Interpersonal planning, troubleshooting, contingency agreements,
5) Positive Involvement: Demonstrating interest, caring, attention.

Staff from Oakland County CMH Authority have described this training as excellent behavioral training combined with superior family therapy training.

Funding of PMTO

The Michigan Department of Community Health is offering $12,500 per staff for up to two staff for up to 9 PIHPs under this RFP. The training will be provided by the Oregon Social Learning Center. The funding will be available on a one-time only, competitive basis. Participants who learn the practitioner model may be qualified to become trainers. PMTO Training costs $25,000 for each participant. PIHPs are encouraged to train two participants who will then become trainers for other staff at their PIHP. Funding will be split 50% DCH/50% PIHP for each participant selected for up to two participants per PIHP. PIHPs may use any fund source that can be used to support staff training for the $12,500 match per participant. Priority will be given to PIHPs that are willing to train two staff and can document the required match. Additional staff could be trained at the PIHP's expense of $25,000 per staff. No budget forms are needed at this time. The PIHP must provide a statement that describes the staff to be trained and the PIHP resources to support staff in the PMTO application. The Department is currently working out an agreement with the MACMHB to contract with the Oregon Social Learning Center.

Staff chosen to participate will need to have an active caseload of at least five families during the training and upon completion of the training and certification, will then be trained to train other staff. Staff chosen to participate should be those that the PIHP believes will be excellent students and upon completion, successful teachers of the model.

Data Collection

Collection of data is a necessary part of the PMTO implementation model to ensure fidelity and tailor the model to Michigan. The following data will be collected as part of this model:

1) Videotaping of sessions will occur and be evaluated by the Oregon Social Learning Center using the Fidelity Implementation (FIMP) instrument.
2) Outcomes will be monitored using the CAFAS.
3) Sessions will be rated after each session by the family using an internet-based tool.
4) A caregiver wish list will be completed on a quarterly basis.
5) The PMTO Support and Consultation form is internet-based and will be completed prior to supervision. The web address for this instrument is: http://www.surveymonkey.com/s.asp?u=139331022908.

PIHP Application Process

PIHPs that are interested in applying to participate in the training are asked to complete the PMTO Application, Project Work Plan, and PIHP and Trainee Readiness Checklists. The combination of these three forms will be used to evaluate the application. Detailed completion will assist in the scoring of the RFP and help to determine which PIHPs will be awarded grant funds. PIHPs should refer to the PIHP and Trainee Readiness Checklists for guidance in responding to the PMTO Application and Project Work plan regarding tasks to be completed.

PART IV. Submission Instructions, Due Date, and Electronic Address for All Responses

Face Sheet, Workplan, and Budget Pages

A face sheet (Attachment A) must be submitted which includes the original signature of the PIHP director, as well as persons employed by the PIHP whom we may contact with any workplan and/or budget questions. A workplan must also be submitted. Include the information you provided in Part I, and describe how the block grant funds will be used to make progress on activities that are not yet completed. Block grant funds are best used to support start-up and developmental activities rather than ongoing services that must be supported by the PIHPs and CMHSPs to sustain change.

For adult practices, a Program Budget Summary and Cost Detail (current DCH forms 385 and 386 are contained in Attachment B) must be submitted for the block grant funds only. Please include a budget narrative that describes how the practice will be sustained on an ongoing basis. Instructions for the budget pages may be found on the MDCH website at www.michigan.gov/mdch.

Federal authorizing legislation specifies that block grant funds **MAY NOT** be used to:

(1) provide inpatient services;
(2) make cash payments to intended recipients of health services;
(3) purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or
(5) provide financial assistance to any entity other than a public or nonprofit private entity.

In addition, this RFP emphasizes the mental health block grant's emphasis upon service provision, and the following restrictions are also included:

(6) no vehicle purchases; and
(7) no administrative or indirect expenses.

The due date for all submissions is **5:00 p.m.** on **July 27, 2005.**

All PIHPs must complete a Submission Checklist (Attachment H), and respond to Part I.

Any PIHP applying for Community Mental Health Block Grant funding for one of the two selected Evidence-Based Practices for adults must also complete a Face Sheet (Attachment A) and respond to Part II.A or Part II.B.

Any PIHP applying on a competitive basis for Community Mental Health Block Grant funding for Parent Management Training Oregon Model must complete a Face Sheet (add to the one for Adult Practices if applying) and respond to Part III.

All submissions must be sent electronically to Karen Cashen, at CashenK@michigan.gov

ATTACHMENT A

ATTACHMENT A

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration
Mental Health System Transformation
PRACTICE IMPROVEMENT INFRASTRUCTURE DEVELOPMENT
FY 2005/2006 AND FY 2006/2007
MENTAL HEALTH BLOCK GRANT
PROPOSAL FACE SHEET

1. PIHP:_____

2. EBP Practices/Population:
   a. Adult Services (*Check only one adult category*)
   ___ Co-Occurring Disorder: Integrated Dual Disorders Treatment (SAMHSA EBP Resource Kit)
   ___ Family Psycho-education (SAMHSA EBP Resource Kit)

   b. Children Services
   ___ Parent Management Training – Oregon Model

3. Proposal Information: *(For Adult EBP)*
   A. Project Title: _____
   B. Total amount of Block Grant funds requested: _____
      Year 1 Amount: _____
      Year 2 Amount: _____

4. Proposal Information: *(EBP for Children)*
   A. Project Title: _____
   B. Total amount of Block Grant funds requested: _____
      Year 1 Amount: _____
      Year 2 Amount: _____

5. Name and telephone number of the individual(s) **at the PIHP** to be contacted regarding this application in the event the review panel requests changes that will make the proposal appropriate to recommend for funding. **The budget person must have the authority to modify the budget forms. The work plan person must have the authority to modify the work plan.**

A. Adult Practice

	Name	Position Title	Telephone No.	E-Mail Address
Budget				
Work Plan				

B. Children Practice

	Name	Position Title	Telephone No.	E-Mail Address
Budget				
Work Plan				

Signature: _____ Date: _____
PIHP Director

ATTACHMENT B

ATTACHMENT B.1

PROGRAM BUDGET SUMMARY

Use Whole Dollars Only MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Program			Date Prepared	Page	Of
Contractor Name			BUDGET PERIOD From: To:		
Mailing Address (Number and Street)			Agreement: ☐ Original ☐ Amendment ▶	Amendment Number	
City	State	ZIP Code	Federal ID Number		

EXPENDITURE CATEGORY				TOTAL BUDGET
1. Salaries and Wages				
2. Fringe Benefits				
3. Travel				
4. Supplies and Materials				
5. Contractual (Subcontracts)				
6. Equipment				
7. Other Expenses:				
8. **Total Direct Expenditures** (Sum of Lines 1-7)	$0	$0	$0	$0
9. Indirect Costs: Rate #1 %				
Indirect Costs: Rate #2 %				
10. **TOTAL EXPENDITURES**	**$0**	**$0**	**$0**	**$0**

SOURCE OF FUNDS:

11. Fees and Collections				
12. State Agreement				
13. Local				
14. Federal				
15. Other(s):				
16. **TOTAL FUNDING**	**$0**	**$0**	**$0**	**$0**

AUTHORITY: P.A. 368 of 1978 **COMPLETION:** Is Voluntary, but is required as a condition of funding	The Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-0385(E) (Rev 4-04) (W) Previous Edition Obsolete. Also Replaces FIN-110

ATTACHMENT B.2

PROGRAM BUDGET – COST DETAIL

Use Whole Dollars Only MICHIGAN DEPARTMENT OF COMMUNITY HEALTH Page Of

PROGRAM	BUDGET PERIOD FROM	TO	DATE PREPARED

CONTRACTOR	ORIGINAL BUDGET ☐	AMENDED BUDGET ☐	AMENDMENT NUMBER

1. SALARY & WAGES – POSITION DESCRIPTION	POSITIONS REQUIRED	TOTAL SALARY	COMMENTS
Total Salaries and Wages	0	$0	

2. FRINGE BENEFITS: (Specify) ☐ FICA ☐ LIFE INS. ☐ DENTAL INS COMPOSITE RATE ☐ UNEMPLOY INS. ☐ VISION INS. ☐ WORK COMP AMOUNT 0.00% ☐ RETIREMENT ☐ HEARING INS. ☐ HOSPITAL INS. ☐ OTHER _____ **TOTAL FRINGE BENEFITS**	$0
3. TRAVEL (Specify if any item exceeds 10% of Total Expenditures) **TOTAL TRAVEL**	$0
4. SUPPLIES & MATERIALS(Specify if any item exceeds 10% of Total Expenditures) **TOTAL SUPPLIES & MATERIALS**	$0
5. CONTRACTUAL (Subcontracts) Name Address Amount **TOTAL CONTRACTUAL**	$0
6. EQUIPMENT (Specify) **TOTAL EQUIPMENT**	$0
7. OTHER EXPENSES (Specify if any item exceeds 10% of Total Expenditures) **TOTAL OTHER**	$0
8. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-7) **TOTAL DIRECT EXPENDITURES**	$ 0
9. INDIRECT COST CALCULATIONS **Rate #1: Base $0 X Rate 0.0000 % Total**	$ 0
Rate #2: Base $0 X Rate 0.0000 % Total	$ 0
10. TOTAL EXPENDITURES (Sum of lines 8-9)	$ 0

ATTACHMENT C

ATTACHMENT C

Co-occurring Disorders: Integrated Dual Disorder Treatment Template for PIHP Planning and Implementation

Please review the following activities related to Co-occurring Disorders: Integrated Dual Disorder Treatment and check the appropriate box indicating where in the process the PIHP is at present.

PIHP: _____

	Activity	Accomplished	In Planning	Not begun
1.	PIHP convenes meetings with other stakeholders including Substance Abuse Coordinating Agencies to address co-occurring disorders.	☐	☐	☐
2.	PIHP identifies a program leader for Co-occurring Disorders: Integrated Dual Disorder Treatment.	☐	☐	☐
3.	PIHP access centers have profession staff that are trained to screen for both mental illness and substance disorders.	☐	☐	☐
4.	Individuals entering the mental health system, or receiving ongoing services, are routinely screened for co-occurring substance disorders.			
5.	PIHP forms an ongoing workgroup of administrators to address Co-occurring Disorders: Integrated Dual Disorder Treatment.	☐	☐	☐
6.	PIHP forms an ongoing workgroup of clinicians to address Co-occurring Disorders: Integrated Dual Disorder Treatment.	☐	☐	☐
7.	PIHP uses the COFIT to assess where the system is with respect to its ability to serve people with Co-occurring Disorders.	☐	☐	☐
8.	PIHP develops an Action Plan that addresses co-occurring capability for the system as a context for the implementation of the COD:IDDT Resource Kit and includes identified training and technical assistance needs.	☐	☐	☐
9.	Providers use the COMPASS to assess themselves.	☐	☐	☐
10.	PIHP builds ongoing training and teamwork into its system.	☐	☐	☐

PIHP: _____

	Activity	Accomplished	In Planning	Not begun
11.	PIHP assesses the system at regular intervals using the COFIT.	☐	☐	☐
12.	Providers assess themselves at regular intervals using the COMPASS.	☐	☐	☐
13.	The General Organizational Index (GOI) and the IDDT Fidelity Tool are administered to determine the degree of implementation.	☐	☐	☐
14.	PIHP Action Plan includes steps to reach full implementation to meet fidelity of the Co-occurring Disorders: Integrated Dual Disorder Treatment Evidence-Based Practice.	☐	☐	☐
15.	PIHP maintains involvement with all relevant regional systems and stakeholders.	☐	☐	☐
16.	PIHP provides or arranges for ongoing technical assistance and training needs for PIHP and provider staff.	☐	☐	☐
17.	PIHP identifies areas of needed clinical improvement and works with workgroups to address needs.	☐	☐	☐
18.	PIHP shares successes and barriers in Co-occurring Disorders: Integrated Dual Disorder Treatment implementation with other regions.	☐	☐	☐
19.	PIHP fully implements the Co-occurring Disorders: Integrated Dual Disorder Treatment Evidence-Based Practice.	☐	☐	☐
20.	Ongoing support for, and measurement of, the model is maintained.	☐	☐	☐

ATTACHMENT D

ATTACHMENT D.1

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase I: Consensus Building **A. Awareness**	1. Create list of all partners to be included in the development & consensus building phase 2. Encourage and collaborate with key stakeholders 3. Identify and use a network from local government, stakeholders, advocacy groups (such as the Depression & Bipolar Support Alliance (DBSA), NAMI, Clubhouses, Drop-in Centers, Mental Health Association), local advisory councils and groups, individual advocates, CMH/PIHP Board Members, PIHP staff 4. Develop a process for obtaining continuous feedback from consumers, families, local NAMI advocates, Clubhouses, drop-in centers, the community and staff	1. May 2005- PIHP selects FPE at the May conference or immediately thereafter 2. June 2005- RFP responses due to MDCH	1. PIHP	1. PIHP selected FPE to implement 2. Local program leaders identified 3. Process for obtaining ongoing input from consumers, families and other stakeholders is identified and a three year implementation plan is developed 4. Respond to MDCH RFP

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase I: Consensus Building B. Education	1. Develop local information using SAMHSA toolkit info 2. Develop and disseminate program document resulting from stakeholders discussing materials, using member newsletters and existing member service functions 3. Develop training plan 4. Produce introductory materials 5. Discussion of stakeholders concerns regarding the model and implementation 6. Provide support and training to PIHP staff 7. Disseminate SAMHSA toolkit information & EBP toolkit implementation strategies	1. Summer 2005 2. Summer/Fall 2005	1.PIHP 2. PIHP	1. Consistency in educational materials used in local implementation of FPE 2.Increase stakeholder buy-in and knowledge 3. Training plan is in place
Phase I: Consensus Building C. Structural & Clinical Improvements	1. Develop, revise and implement work flow and other administrative processes 2. Identify information systems requirements 3. Educate Board members and Executive Directors 4. Educate and train staff	1. 6/2005 – 12/2005 - develop & implement plan to revise agency processes as necessary 2. 6/2005 – Information system requirements identified 3. 12/2005 – Information systems can support monitoring and tracking FPE activities 4. Summer/fall 2005- develop & implement plan for Director, Board and staff training	1. PIHP	1.Consistent information systems design to support data collection, aggregation and reporting of data/results 2. PIHPs have developed and made available to staff clinical and administrative supports 3. PIHP will have developed and implemented a plan for training and support
Phase I: Consensus Building D. Adaptation & Evaluation	1.Develop and implement data collection, integration into local QI process and knowledge information system and analysis 2.Review Model: Propose local adaptations which must be reviewed and approved by FPE subcommittee 3.Implement appropriate progress report structure developed by state FPE Subcommittee to test initial fidelity and outcomes measures	1. May 2005 - PIHPs receive fidelity measures from MDCH 2. Aug. 2005 – PI measures introduced with plan for how data will be collected, interpreted, analyzed and what will be done with data 3. Fall 2005 – General Organizational Index	1. PIHP	1. Consistent implementation of data collection procedures for fidelity measures 2. EBP fidelity maintained through careful review of all changes and adaptations to model 3. Consistent implementation of the model through fidelity monitoring

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase II: Enacting A. Awareness	1. Develop plan for continuous feedback on model and service 2. Implement process for obtaining continuous feedback from consumers, family, local NAMI advocates, Clubhouses, Drop-in Centers, the community and staff	1. January 2006	1. PIHP	1.Continuous plan for feedback on model & service developed and implemented 2.Consumers, families and local advocates support the program and demonstrate buy-in by recommending the program to others
Phase II: Enacting B. Structural & Clinical Improvement	1. Implement process to collect and analyze data and identify opportunities for improvement 2. Develop defined competencies for clinical staff	1. January 2006	1. PIHP	1. PIHP uses data to inform decision-making to improve internal processes 2. Core set of clinical competencies identified and training developed to support clinical & administrative improvements
Phase II: Enacting C. Continual Improvement & Support	1. Use performance data to inform all decision-making 2. Enhancements in training needs defined and developed 3. Local implementation of additional EBPs (such as Integrated Treatment of Individuals with Co-Occurring Disorders, ACT, etc.)	1. January 2006 – Report to MDCH 1st year data 2. January – March 2006 – Training needs presented to MACMHB 3. October 2007	1. PIHP staff and quarterly supervision group 2. PIHP 3. PIHP	1. PIHP uses data to inform decision-making to improve internal processes 2. State-wide identified training needs developed and made available to PIHPs 3. Layering of EBP to enhance clinical outcomes for consumers

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase II: Enacting D. Adaptation & Evaluation	1. Analyze fidelity measures and other performance data to make ongoing monitoring and funding decisions 2. Discuss planning for 3rd year of implementation of project	1. January – April, 2006	1. PIHP	Outcomes data: -Consumer satisfaction -Staff satisfaction -Improvement in quality of life for consumers as measured by: reduced hospitalization rates; reduced consumer contacts with the criminal justice system; meaningful involvement in the community; increased consumer compliance with medications; improved participation in treatment process; improved consumer perception of recovery; improvement in meaningful family relationships; increase in number of consumers in supported employment; improved physical health status

FAMILY PSYCHOEDUCATION TEMPLATE FOR PIHP PLANNING

Implementation Strategy	Activity	Milestones/Dates	Person Responsible	Outcomes
Phase III: Sustaining: A. Awareness	1. Community is actively involved in the support groups 2. PIHP will develop mechanism to track referrals into the group from the community, consumers and other local stakeholder groups 3. Use data for outreach to consumers and families	1. October 2006 – September 2007	1. PIHP	1. Family and consumer buy-in to program results in referrals to program 2. Process in place for PIHP to count the number of referrals coming from community & consumers
Phase III: Sustaining: B. Education	1. With key stakeholders, provide educational forums to legislative, advocacy and local community groups	1. October 2006 – September 2007	1. PIHP	1.Increased understanding of mental illness by consumers, families and policy makers 2.Improvement of local communities' understanding of mental illness and FPE 3.Involvement of NAMI, consumers and families in FPE's group facilitation
Phase III: Sustaining: C. Structural and Clinical Improvement	1. Build capacity for expansion of groups	1. October 2006 – May 2007:	1. PIHP	1.Of those PIHP that have chosen FPE EBP, 95% of their counties will have implemented FPE by the 3rd year of the project 2. Data collection and monitoring system implemented and fully functional
Phase III: Sustaining: Adaptation & Evaluation	1.Create a local level evaluative capacity to monitor performance against outcomes 2. Identify and document local innovations	1. October 2006 – May 2007 – Data collection and monitoring system implemented and fully functional 2. October 2006 – September 2007	1. PIHP 2. PIHP	1. PIHP share FPE results and outcomes with consumers, community and other interested stakeholders 2. Local innovations documented and shared with FPE Subcommittee and MDCH

Attachment D.2

Family Psychoeducation
RFP Checklist

PIHP Proposal includes:

☐ 1. Description of PIHP team that will implement FPE: names, titles, and roles in implementation, percent of each FTE devoted to the project

☐ 2. Identification of what affiliates (if applicable) and provider networks (if applicable) will participate. Description of their roles.

☐ 3. Evidence that the first four activities in the Consensus Building Awareness Phase (on the work plan) have begun: a list of all the partners to be included in the development and consensus phase; evidence of collaboration with key stakeholders; evidence of at least one meeting with network; evidence that development of a continuous feedback plan has begun

☐ 4. A work plan that uses the attached template. If PIHP has begun implementation of FPE, indicate on the work plan the outcomes that have been accomplished in each phase. Work plan should clearly identify phases and activities to be completed, with milestones and dates, specific PIHP staff responsible and intended outcomes.

☐ 5. As applicable, a statement of intent for voluntary involvement in statewide outcomes measurement

☐ 6. A detailed narrative that indicates how the PIHP will spend the Block Grant funds

Assurances
The PIHP will:

☐ Support clinicians' participation in FPE training, consultation and supervision that is offered or co-sponsored by MDCH

☐ Use SAMHSA Toolkit as basis for implementation

☐ Participate in fidelity monitoring

☐ Provide requested quality improvement and satisfaction data to MDCH, or MDCH-sanctioned evaluators

☐ Will properly code encounter data so that MDCH and evaluators may track the utilization of FPE practices

ATTACHMENT E

ATTACHMENT E

Parent Management Training, Oregon Model (PMTO) 3/27/2005

Grandfather of theoretically grounded evidence based practices

Developed mid 1960's by Gerald R. Patterson
Lineage: John B. Reid, Patricia Chamberlain, Marion Forgatch, Thomas Dishion
Manualized interventions for individual family and group applications
Published findings for clinical & prevention studies; parent and youth outcomes

Tailored for serious behavior problems for youth from preschool through adolescence

- Overt antisocial behavior (aggression, defiance, hyperactivity, fighting)
- Covert antisocial behavior (lying, stealing, truancy, fire setting)
- Internalizing problems (depressed mood, peer problems, deviant peer association)
- Delinquency
- Substance abuse
- School Failure

Applied with multi-problem families

- Parents with psychopathology (depression, anxiety, antisocial)
- Family contextual problems (poverty, poor neighborhoods)
- Family structure transitions (divorce, repartnering)
- Marital conflict

Family intervention designed to empower parents

- Parents as primary treatment agents
- Identify and build on strengths in family
- Skills training in effective parenting practices for parents
    - Skill Encouragement: Teaching new behavior through positive contingencies
    - Limit Setting: Discouraging deviant behavior through negative noncorporal sanctions
    - Monitoring/Supervision: Attending to children's behavior at home and away from home
    - Family Problem Solving: Interpersonal planning, troubleshooting, contingency agreements
    - Positive Involvement: Demonstrating interest, attention, caring.
- Intervenes with family members and subsystems as necessary
    - Couples
    - Youngsters
    - Siblings

Intensive training by highly qualified professionals

- Workshops
- Biweekly group consultation based on direct observation of family treatment
- Fidelity assessed from observation of family treatment

- Certification in method

PMTO Workshop Expectations

The trainee must agree to participate in at least 85% of the following workshops, coaching/supervision, consultation and video taping. Must attend the first three trainings.

Workshops: 6 @ 3 days each; 18 days total for complete program

Workshop 1 (Month 1)

- ❑ Foundations
- ❑ Role Play
- ❑ Directions
- ❑ Encouragement
- ❑ Setting Limits
- ❑ FIMP introduction
- ❑ Assignment in workshop: make 2 fictional videotapes (directions and encouragement)

Workshop 2 (Month 2, 4 weeks later)

- ❑ Encouragement, part 2
- ❑ Setting Limits, part 2
- ❑ Introducing PMTO to families
- ❑ Troubleshooting
- ❑ Process Skills (Problem Solving, Questioning, Structuring, Managing Misalignment)
- ❑ Observational Assessment Methods
- ❑ FIMP applications
- ❑ Assignment in workshop: make 2 fictional videotapes (setting limits; troubleshooting)

Workshop 3 (Month 3, 4 weeks later)

- ❑ Family Problem Solving
- ❑ Monitoring
- ❑ Applications to other issues (adjusting to family situations/contexts, school, siblings
- ❑ FIMP applications
- ❑ Assignment: immediately after workshop begin working with real families

Workshops 4, 5, and 6 (Months 5, 8, and 11)

- ❑ Case consultations
- ❑ Adaptations and applications to fit contexts and population
- ❑ Troubleshooting and coaching PMTO
- ❑ Additional dimensions (understanding theoretical model, managing emotions, school adaptations, integrating theory and adaptations to intervention, deepening understanding)

Certification Completion (Between months 11-15)

- ❑ Continued twice monthly telephone consultation until certification
- ❑ Completion of training families
- ❑ Achieve *Pass* on certification tapes

Videotaped therapy:

- All candidates treat a minimum of 5 families, video recording all sessions
- Treat 3 families (video discs sent to Oregon, viewed, and feedback on selected sections of sessions). Treatment includes training in all 5 core PMTO components
- Appropriate labeling of video recording of family sessions
- Session information forms included with each video recording
- Secure mailing of sessions video recordings within one week of session
- Appropriate consent forms obtained
- 2 certification families (video recordings sent for evaluation based on 2 sessions per family—troubleshooting encouragement and troubleshooting limit setting)

Consultation Meetings

- Meetings with each site coach (twice monthly)—needs some adjustment for the PIHP training as they are located all over state—perhaps contact with the state coordinator.
- Telephone consultations based on video recorded sessions (twice monthly)

Certification as PMTO Specialist

- Complete entire program
- Pass (FIMP score of 6 or better) all four certification sessions

PMTO Phase One Work Plan
May 20, 2005

Goal: Improve child and family well-being through use of Parent Management Training (Oregon Model) and outcomes management.

Outcomes: PMTO will be implemented statewide with model fidelity (Measurement: FIMP).
Improved child and family functioning (Measurement: CAFAS).
Improved family satisfaction with services (Measurement: OSLC satisfaction questions added to support tool)
Improved Parenting Skills (Advance Child Management Parenting Scale) (Care Giver Wish List - Optional)
Improved staff skills/competency in PMTO (FIMP)

Outcome	Actions	Entity Responsible	Milestones/Dates
1. PMTO will be implemented statewide with model fidelity (Measurement: FIMP).	**Education/ Awareness**		
	Develop Awareness through MACMHB Conference	PMT Committee	5/24-25/2005
	Review cultural issues related to PMTO and share information	PMT Committee	10/1/2005
	Share information with stakeholders, including information about the model, benefits, and work plan.	PMT Committee	10/1/2005
	Share information with Children's administrators	MDCH	ongoing
	Share information about training at conferences	MDCH/CMH Board Association	ongoing
	Share information about PMTO, training with ACMH family members at conferences in communities etc.	ACMH	5/1/2005

Outcome	Action	Entity Responsible	Milestones/Dates
Outcome No. 1 Continued	**Family Involvement**		
	Ensure that families are involved at all levels including training at state and local levels, data gathering, evaluation of data and interpretation and feedback	MDCH/PIHP/ACMH	5/1/2005
	Training and Technical Assistance		
	Provide Parent community training at each site about family, voice, choice, system training, and families roll at each site.	MDCH/PIHP/ACMH	11/1/05
	Purchase equipment needed for training, digital DVD video camera, tripod, wide angle lens, separate microphone, DVD's for recording and copying, computer with internet access.	PIHP	9/1/2005
	Identify staff to be trained	PIHP/CMHSP	9/1/2005
	Identify cases to use in training (minimum of 5)	PIHP/CMHSP	9/1/2005
	Provide training to participants in use of video equipment	MDCH/OSLC/PIHP/ ACMH	11/1/2005
	Provide training in data collection	EMU/OSLC/MDCH/PI HP	11/1/2005
	Provide training in PMTO	OSLC	1/1/2006
	Complete a minimum of 3 training cases	MDCH/OSLC/PIHP	6/1/2006
	Provide ongoing feedback to trainees	PIHP/OSLC	1/1/2006
	PIHP staff begin training others	MDCH/OSLC/PIHP	1/1/2006
	Put training and TA material (practice manual) on list serve	MDCH/PIHP/OSLC	11/1/2006
	Develop new training and Training and TA manual	MDCH/PIHP/OSLC	11/1/2006
	Hold a training and TA session for old and new sites	MDCH/PIHP/OSLC	11/1/2006
	Identify and distribute criteria for certification	MDCH/PIHP/OSLC	1/1/2006
	Develop in state capacity for FIMPing (virtual institute)	MDCH/PIHP/OSLC	1/1/2007
	Families participate in leadership/system change training	MDCH/PIHP/ACMH	1/1/2006
	Families will participate in state training	MDCH/PIHP/OSLC/ ACMH	1/1/2006
	Families are included in local training	PIHP/ACMH	1/1/2007
	ACMH will provide training in family involvement/engagement/welcoming and family voice	MDCH/PIHP/ACMH	1/1/2006

Outcome	Action	Entity Responsible	Milestones/Dates
Outcome No. 1 continued	**Funding**		
	Apply for R-34	MDCH/OSLC/Kay	6/1/2005
	Apply for R-01 Grant	MDCH/OSLC/Kay	10/1/2005
	Make Mental Health Block Grant funds available through RFP	MDCH	10/1/2005
	Identify funding at CMHSP/PIHP level	PIHP/CMHSP	10/1/2005
	Continue contracts with EMU for CAFAS data collection	MDCH/EMU	10/1/2005
	Develop new contracts with EMU and OSLC for training and evaluation	MDCH	10/1/2005
	Administration		
	Complete Institutional Review Board requirements and share consent forms with training sites	MDCH/OSLC/EMU/ ACMH	10/1/2005
	Identify HCPCS Codes/Modifiers for O.P. and H.B. that include a face to face exception	MDCH	5/1/2005
	Complete RFP Selection Criteria and provide to CMHSP/PIHP	MDCH/PIHP	5/1/2005
	Select trainee sites	MDCH	8/1/2005
	Integrate families into outcome management process that may include gathering and interpreting data and quality improvement processes	MDCH/PIHI/ACMH	5/1/2005
	Develop new job descriptions to include PMT training for those who receive training.	PIHP/CMHSP	10/1/2005
	Develop practice guidelines and utilization management standards for statewide use	PIHP/MDCH/OSLC	10/1/2005

Outcome	Action	Entity Responsible	Milestones/Dates
Outcome No. 1 Continued	Integrate outcome management, PMTO into MDCH site review processes	MDCH/PIHP/CMHSP	Develop a plan within 2 years for statewide implementation using evaluation data from pilot sites
	Include requirement to train staff in PMTO in MDCH/PIHP contract	MDCH	
	Include requirement to have PMTO available in MDCH/PIHP contract	MDCH	
	Develop plan to interface with juvenile justice and child welfare	PMT Committee/ACMH	10/1/07
	Test use of PMTO as group/prevention intervention	MDCH/PIHP/OSLC	10/1/2007
	Support development of Evidence Based Practice in PIHP/CMHSP including other approaches, CBT, MST, FFT	MDCH/PIHP	Ongoing
	Measurement		
	Identify and finalize measures to be used	PMT Committee	5/9/2005
	Develop clear process outlining what data is collected when and by whom with and without additional funding	MDCH/PIHP/EMU/ OSLC	5/9/2005
	Develop a feedback loop to inform participants about the process, fidelity, and outcomes	MDCH/CMHSPs/ ACMH	10/1/2005
	Use data to inform decision-making process	MDCH/PIHP/CMHSP/ ACMH	10/1/2006
	Identify improvements in the model	PIHP'CMHSP/OSLC	10/1/2007
	Monitor Fidelity	MDCH/OSLC	Ongoing
	Develop Michigan Fidelity monitors	MDCH/PIHP/EMU	10/1/2007

Outcome	Action	Entity Responsible	Milestones/Dates
2. Improved child and family functioning (Measurement: CAFAS).	Expand LOF project (sites will be required to participate in LOF project to be selected for training)	MDCH/EMU	5/1/2005
	Provide education and training on the CAFAS	MDCH/EMU/Kay/ ACMH	10/1/2005
	Provide training to ACMH members in the use of CAFAS and family centered practice	ACMH/CMHSPs	10/1/2006
	Ensure that rater's are reliable raters and monitor them regularly	MDCH/EMU/Kay	Ongoing
	Provide Training in automated CAFAS	MDCH/EMU/PIHP's	1/1/06
3. Improved family satisfaction with services (Measurement: OSLC questions added to support tool)	Modify support tool	Kay/OSLC	5/1/2005
	PMT committee review support tool	PMT committee	5/16/2005
	Tool is revised	Kay/OSLC	5/24/2005
	Tool implemented	MDCH/PIHP/OSLC	1/1/2006
	Include ACMH in interpretation of statewide data	MDCH/EMU/ACMH	10/1/06
	Involve ACMH in training of how to use satisfaction questions	MDCH/EMU/ACMH	1/1/06
4. Improved Parenting Skills (Measurement: Caregiver Wish list/Skill Building Planner)	Tools tested	Kay/PIHPs/ACMH	6/1/2005
	Tool revised	Kay/PIHPs/ACMH	9/1/2005
	Tool implemented	MDCH/Kay/PIHPs	10/1/2005
5. Improved staff skills/competency in PMTO (Measurement: FIMP)	Train Staff	OSLC/PIHP	1/1/2006
	FIMP	OSLC/PIHP	3/1/2006
	Monitor family skills training and client outcomes	OSLC/PIHP/EMU	3/1/2006

Parent Management Training – Oregon Model (PMTO) Application

Please refer to the PMTO Readiness Checklist tasks in developing your responses.

PIHP : _____

Describe the ability of the PIHP to meet the fiscal support requirements for PMTO, including a detailed description and source of PIHP funding. (30 points)
Describe the PIHPs ability and willingness to participate in the evaluation of PMTO training and implementation. (10 points)
Describe the ability of the PIHP to support staff and make them available to meet the requirements of PMTO. (10 points)

Describe what roles and responsibilities family members will have in this project, other than as a recipient of services. Please describe your reimbursement methods as they relate to family involvement. Attach any policies/guidelines that exist to support reimbursement for families. (10 points)
Describe the staff that will participate in PMTO training, selection process, their education, experience, current roles, and rationale for their participation. Please also describe the PIHPs commitment to how these roles will change with the implementation of PMTO and local dissemination plan. (30 points)
Describe how PMTO will fit in with system transformation efforts in the PIHP. Please also include how PMTO will fit with the Evidence-Based Practice Leadership Team efforts, as described in RFP. Please include a discussion about sustainability of PMTO. (10 points)

Project Work Plan

Please develop and complete a detailed project work plan using the format below. The workplan should include activities from preparing for PMTO training **through** dissemination of the model to other staff.

Project Activity	Anticipated Date of Completion	Responsible Party

PIHP READINESS CHECK LIST

This questionnaire is designed to assess your willingness to participate in the training procedures for Parent Management Training, the Oregon Model (PMTO). PMTO is a program that strengthens the child-rearing practices of parents of children with behavior problems, thus reducing behavior problems.

As you rate the items below, use the 4-point scale from *1=Completely Disagree* to 4=*Completely Agree* to indicate your willingness to carry out the work described in each item.

1 = Completely Disagree **2 = Generally Disagree** **3 = Generally Agree** **4 = Completely Agree**

TASK	RATING
FISCAL SUPPORT	
1. We will pay for training expenses, which include:	
a. DVD mailing expenses sent to Oregon by Fed Ex.	1 2 3 4
b. Telephone expenses for the consultations.	1 2 3 4
c. Workshop expenses for trainees (transportation, lodging, per diem, etc).	1 2 3 4
2. We agree to provide the following:	
a. Small incentives	1 2 3 4
b. Printing for parent handouts and notebooks	1 2 3 4
c. Staff to produce materials for families	1 2 3 4
3. We agree to purchase proper equipment that includes:	
a. Digital DVD video camera, tripod, wide-angle lens, separate microphone, DVD's for recording/copying.	1 2 3 4
b. Copy capability (enables copying DVD's to send one to Oregon and one retained original).	1 2 3 4
c. A computer with internet access so trainee can complete forms once per week.	1 2 3 4
4. We agree to provide match of $12,500 (1:1 match) to support participation of one staff to be trained.	1 2 3 4
5. We agree to provide match of $25,000 (1:1 match) to support participation of two staff to be trained.	1 2 3 4
6. We agree to support participation of additional staff to be trained at PIHP expense of $25,000 per participant.	1 2 3 4
CAFAS/EVALUATION	
7. We will participate in the Level of Functioning (LOF) project with EMU and MDCH.	1 2 3 4
8. We will use the CAFAS software to record the data on clients seen by trainees and send to LOF monthly.	1 2 3 4

9. All data fields will be entered for the CAFAS (not just summary scores).	1	2	3	4
10. We will follow procedures to ensure that trainees have "Prime PMTO cases". All cases will be reviewed at intake to determine if they meet the following criteria on the CAFAS (a) 20 or 30 on Home, (b) 20 or 30 on School or Behavior Toward Others and (c) no 30's on Community, Self-Harm, Mood, Substance Use or Thinking.	1	2	3	4
11. We will follow the Michigan Department of Community Health's IRB procedures.	1	2	3	4
12. We will have signed consents for all children and families participating in the training.	1	2	3	4
13. We will complete the caregiver skills scale on a quarterly basis.	1	2	3	4
14. We will complete family satisfaction data after each session.	1	2	3	4
STAFF SUPPORT/AVAILABILITY				
15. We will provide trainee with time to prepare and debrief cases (Approximately 2 hrs per week)	1	2	3	4
16. We will develop a job description for trainees during the training that includes:				
a. Sufficient time to attend workshops, weekly supervision meetings and twice monthly consultations.	1	2	3	4
b. A sufficient number of families to treat within appropriate training time frames.	1	2	3	4
c. Sufficient time and support to conduct the treatment necessary for the training (minimum of 5 families), approximately 2 hours per week per family.	1	2	3	4
d. Training activities as a significant dimension and portion of their job.	1	2	3	4
17. We will follow procedures to ensure that trainees have:				
a. 2 Prime PMTO cases with a minimum of 8 DVDs of completed sessions before Workshop 1.	1	2	3	4
b. A minimum of 5 cases available for participation in the training within the schedule of the training.	1	2	3	4
c. At least 1 case (of the 5) will be ready to begin treatment by the beginning of the 3rd workshop.	1	2	3	4
d. At least 2 more cases (of the 5) will be ready to begin treatment by the 4th workshop.	1	2	3	4
e. Two more cases will be treated as certification cases starting no sooner that the 4th workshop.	1	2	3	4
FAMILY INVOLVEMENT				
18. We will ensure that families will participate in:				
a. Planning for PMTO.	1	2	3	4
b. Activities related to implementation of PMTO.	1	2	3	4
c. Evaluation activities.	1	2	3	4
d. Training of PMTO therapists.	1	2	3	4

PLAN FOR DISSEMINATION				
19. Upon training completion, we will:				
a. Develop a new job description for the trainee to allow them to use the new PMTO skills as practitioner, coach, or trainer, as appropriate.	1	2	3	4
b. Ensure that training others will not be an add-on to current job.	1	2	3	4
20. We will commit to replace dropouts (trainees and training cases for trainees).	1	2	3	4

TRAINEE READINESS CHECK LIST

This questionnaire is designed to assess your willingness to participate in the training procedures for Parent Management Training, the Oregon Model (PMTO). PMTO is a program that strengthens the child-rearing practices of parents of children with behavior problems, thus reducing behavior problems.

As you rate the items below, use the 4-point scale from *1=Completely Disagree* to 4=*Completely Agree* to indicate your willingness to carry out the work described in each item.

1 = Completely Disagree **2 = Generally Disagree** **3 = Generally Agree** **4 = Completely Agree**

TASK	RATING
1. I will follow the appropriate consent procedures with all training program participants.	1 2 3 4
2. I will become a reliable rater of the CAFAS and/or maintain my reliable status	1 2 3 4
3. I will collect CAFAS data on all youths I treat during the training period, not just PMTO cases.	1 2 3 4
4. I will attend 85% of each of the following training activities:	
a. 18 workshop days (6 workshops, 3 days each)	1 2 3 4
b. Twice monthly telephone case consultations	1 2 3 4
5. I will carry out treatment assessments as follows:	
a. Pre/post assessments of families (e.g., CAFAS, videotaped family interactions, questionnaires)	1 2 3 4
b. Video recording of all family sessions (equipment will be provided)	1 2 3 4
c. Completion of weekly web-based assessments of training activities	1 2 3 4
6. Before Workshop 1, I will use my usual treatment methods with 2 PMTO suitable cases and will collect baseline data from these families. I will complete the following activities:	
a. Pre treatment assessments, and post assessments as ready	1 2 3 4
b. Video recording of all family sessions	1 2 3 4
c. Completion of weekly assessments	1 2 3 4
d. I will bring copies of at least 8 DVDs from these family sessions to Workshop 1	1 2 3 4
7. In addition to the 2 baseline cases described above, I will complete a minimum of 3 PMTO cases (more may be required), including the following:	

a. Completing sessions on all 5 core PMTO components	1	2	3	4
b. Pre/post treatment assessments	1	2	3	4
c. Video recording of all family sessions	1	2	3	4
d. Completion of weekly assessments	1	2	3	4
e. Sending DVD recordings to the consultants	1	2	3	4
8. I will complete 2 additional certification cases, including the following:				
a. Pre/post treatment assessments	1	2	3	4
b. Video recording of all family sessions	1	2	3	4
c. Completion of weekly assessments	1	2	3	4
d. Sending DVD recordings to the consultants	1	2	3	4
e. Attaining a passing score on each of 4 sessions on the following topics: troubleshooting encouragement and troubleshooting limit setting	1	2	3	4
9. I will come to Workshop 3 with 1 new PMTO case ready to begin therapy.	1	2	3	4
10. I will come to Workshop 4 with 2 additional new PMTO cases ready for therapy.	1	2	3	4
11. I will collect and submit weekly family satisfaction data for each case.	1	2	3	4
12. I will complete the internet Training Support Tool each week.	1	2	3	4
13. I will send DVDs to the training consultants according to schedule.	1	2	3	4

ATTACHMENT F

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EVIDENCE-BASE PRACTICES KEY DEFINITIONS:

Emerging Practices – Emerging practices are new innovations in clinical or administrative practice that address critical needs of a particular program, population or system, but do not yet have scientific evidence or broad expert consensus support.

Evidence-Based Practices (EBPs) – Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Institute of Medicine, 2001), or clinical or administrative interventions or practices for which there is consistent scientific evidence showing that they improve client outcomes (Drake, et al. 2001). The term "evidence-based practices" sometimes encompasses all the terms that follow about best, promising, and emerging practices.

Integrated Treatment – Co-occurring Disorder treatments combine or integrate mental health and substance use interventions at the level of the clinical encounter. Hence integrated treatment means that the same clinicians or team of clinicians, working in one setting, provide appropriate mental health and substance use interventions in a coordinated fashion. In other words, the service provider takes responsibility for combining the interventions into a coherent package. For the individual with a co-occurring disorder, the service appears seamless, with a consistent approach, philosophy and set of recommendations. The need to negotiate with separate clinical teams, programs or systems disappears. The goal of co-occurring diagnosis interventions is recovery from two serious illnesses.

Promising Practices – Promising practices are clinical or administrative practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.

Evaluation /Measurement – These are types of evidence that compare a practice or intervention to the same situation before the introduction of the practice or intervention, or describe the positive and negative results of an intervention or practice, without comparison to other times or conditions. Evaluations and demonstrations can be more or less controlled and more or less rigorous, depending on how they are planned and conducted.

Improving Practices Leader- A designated Improving Practices Leader implements the program by ensuring that administrative mechanisms support clinical operations and system change. The leader must attend to both the processes involved in providing care and all the related supporting processes (e.g., records, utilizing personnel, resources billing, staff training, and information systems etc.).

Intervention – Intervention is a change in practice, policy, financing mechanism, practitioner, setting, environment, approach or oversight that is expected to have positive results.

Adoption – Adoption is the difficult process of planning, implementing and sustaining practices or interventions that have some evidence to suggest they are likely to or may produce positive results. This process may include behavioral changes at an individual or an organizational level. Adoption implies attention to fidelity to all the key elements of a proven practice and takes careful planning and sustained effort to achieve in routine practice the results achieved and reported in scientific studies.

Fidelity – Fidelity is adherence to the key elements of an evidence-based practice, as described in the controlled experimental design, and that are shown to be critical to achieving the positive results found in a controlled trial. Studies indicate that the quality of implementation strongly influences outcomes. While there is much discussion in the field about the need to maintain fidelity to the experimental design that produced the positive results, increasingly there is discussion about the need to research and rigorously evaluate practices in routine settings so that the things that are more likely to produce good outcomes in such settings are identified and supported.

Sustainability – Sustainability is the ability of an organization or individual to continue over time the implementation of a practice or intervention with continuing fidelity to key components that create the positive results.

Influences and Barriers to Adoption – These are actions or issues that encourage or impede adoption of a new practice or intervention. These may include but are not limited to organizational structure, policies and procedures, payment mechanisms, organizational or individual culture or comfort with change, size or age of the organization, history or experience with other recent changes, mandates or incentives.

ATTACHMENT G

ATTACHMENT G

RESOURCES

I. Adult Practices:

1. Evidence-Based Practices Implementation Resource Kits
   a. Co-Occurring Disorders:Integrated Dual Disorders Treatment
   http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/
   b. Family Psycho-education
   http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/

2. Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders
   U.S. Department of Health and Human Services, SAMHSA November 2002
   http://alt.samhsa.gov/reports/congress2002/index.html

3. The President's New Freedom Commission on Mental Health
   Achieving the Promise: Transforming Mental Health Care in America – Final Report
   http://www.mentalhealthcommission.gov/reports/reports.htm

4. Substance Abuse Treatment For Persons With Co-Occurring Disorders
   A Treatment Improvement Protocol TIP 42
   http://media.shs.net/prevline/pdfs/bkd515.pdf

5. Substance Abuse Treatment: Group Therapy
   A Treatment Improvement Protocol TIP 41
   http://media.shs.net/prevline/pdfs/bkd507.pdf

6. Michigan Mental Health Commission - Final Report
   http://www.michigan.gov/mentalhealth/0,1607,7-201--98116--,00.html

7. Transforming Mental Health Care in Michigan
   MDCH's Plan for Implementing Recommendations of the Michigan Mental Health Commission
   http://www.michigan.gov/documents/DCH_Implementation_Plan_April_2005_12 2025_7.pdf

8. Turning Knowledge into Practice
   A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices
   Hyde, Falls, Morris, Schownwald 2003, The Technical Assistance Collaborative, Inc. and The American College of Mental Health Administration (ACMHA)
   http://www.tacinc.org/cms/admin/cms/_uploads/docs/EBPmanual.pdf

9. Implementation Research: A Synthesis of the Literature
   University of South Florida. Fixen, Naoom, Blasé, Friedman, Wallace 2005
   http://nirn.fmhi.usf.edu/resources/publications/Monograph/index.cfm

Some useful Websites:

1. CCISC Model
   http://zialogic.org/CCISC.htm (Drs. Minkoff and Cline)
2. Evidence-Based Practices Information Guide for Consumers, Providers, etc.
   http://mentalhealthpractices.org/

CCISC evaluation tools:

The State of Michigan/MDCH has procured licenses for the following tools:

1. Tool Number 10 - CO-FIT 100™ (Version 1.0) CCISC Outcome Fidelity and Implementation Tool
2. COMPASS © (Version 1.0) Co-morbidity Program Audit and Self-Survey for Behavioral Health Services
3. CODECAT © (Version 1.0) Co-occurring Disorders Educational Competency Assessment Tool

These tools are available to PIHPs, CMHSPs, and CAs. For information on obtaining these evaluation tools, COD:IDDT Work Plans, the names of Subcommittee chairs or other members, or need further information on resources, please contact Tison Thomas at (517) 241-2616 or thomasti@michigan.gov.

II. PMTO References

1. PMTO Logic Model

2. PMTO Support and Consultation tool
   (http://www.surveymonkey.com/s.asp?u=139331022908)

3. Family Satisfaction with Session tool

4. Consent forms for families, therapists, agencies, supervisors

5. List of equipment needed and estimated price

6. Caregiver Wish List

7. Statement of Michigan Level of Functioning Requirements and Benefits

8. Statement of Target PMTO case and how to figure it out from CAFAS

9. HIPAA business agreement from Kalamazoo

10. Best Practice Structure and Framework for Support from Oakland

11. Some Things to Consider When Planning to Implement Evidence-Based Practices for Children, Families, or Adults in Human Service Systems by Dean Fixsen

12. PMTO Excerpt from *Guide for Matching CAFAS Profiles to Evidence-Based Treatments: A Compilation of Resources (Hodges, 2004)*

13. Oregon Social Learning Center: http://www.oslc.org

14. Extensive Review of implementation evaluation literature can be found at: http://nirn.fmhi.usf.edu/resources/publications/Monograph/index.cfm

15. Turning Knowledge into Practice document http://www.tacinc.org/cms/admin/cms/_uploads/docs/EBPmanual.pdf

19. Questions related to PMTO implementation in Michigan should be directed to:
    Jim Wotring, 517-241-5775 or wotringj@michigan.gov or
    Doug Nurenberg, 517-241-5772 or nurenbergd@michigan.gov

ATTACHMENT H

ATTACHMENT H

SUBMISSION CHECKLIST

Please check the boxes for all items submitted.

PART I (Required)	
☐	Improving Practice Leadership Team Membership Form
☐	One page summary of how the Team will be operationalized
PART II (One service required; application for block grant funds for one practice or the other is strongly encouraged)	
A.	**Co-Occurring Disorder: Integrated Dual Disorder Treatment (COD:IDDT)**
☐	Face Sheet
☐	COD:IDDT Template for PIHP Planning and Implementation
☐	Project Budget Summary and Project Budget Detail for FY05/06 (DCH-0385-0386)
☐	Workplan for FY05/06
☐	Project Budget Summary and Project Budget Detail for FY06/07 (DCH-0385-0386)
☐	Workplan for FY06/07
B.	**Family Psychoeducation**
☐	Face Sheet
☐	Family Psychoeducation Template for PIHP Planning
☐	Project Budget Summary and Project Budget Detail for FY05/06 (DCH-0385-0386)
☐	Workplan for FY05/06
☐	Project Budget Summary and Project Budget Detail for FY06/07 (DCH-0385-0386)
☐	Workplan for FY06/07
PART III Parent Management Training - Oregon Model (Optional)	
☐	PMTO Application
☐	PMTO Workplan
☐	PIHP Readiness Checklist and Trainee Checklist